

**FACILITATOR’S NOTES FOR
“CARE SEEKING EXPERIENCES OF HOUSEHOLDS IN SRI LANKA”**

OBJECTIVES OF CASE STUDY

1. To develop an understanding of care seeking experience and health service access issues;
2. To consider the relevance of both direct and indirect costs of health care use; and
3. To develop an understanding of the household level impacts of illness and health care use and the strategies used by households to cope with these impacts.

PREPARATION FOR CASE STUDY

In preparing for facilitating this case study, the following readings will provide a good overview of the issues that will arise during group and plenary discussion:

Thiede M, Akweongo P, McIntyre D (2007). Exploring the dimensions of access. *In*: McIntyre D, Mooney G (eds). *The economics of health equity*. Cambridge: Cambridge University Press.

(This chapter discusses the concept of access and the main dimensions of access)

Whitehead, M., Dahlgren, G., & Evans, T. (2001). Equity and health sector reforms: Can low-income countries escape the medical poverty trap? *Lancet*, 358, 833-836

(This article provides an introduction to the concept of the medical poverty trap)

Perera M, Gunatilleke G, Bird P (2007). Falling into the medical poverty trap in Sri Lanka: what can be done? *International Journal of Health Services*, 37(2): 379-398.

(This article provides useful background information on the Sri Lankan health system and discusses the medical poverty trap in the context of health care use in Sri Lanka)

McIntyre D, Thiede M, Dahlgren G, Whitehead M (2005). What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts? *Social Science and Medicine* 62: 858-865.

(This article provides an overview of the kinds of costs (direct and indirect) borne by households when ill and as a result of using health services as well as the strategies that households commonly use to cope with these costs)

Dahlgren G, Whitehead M (2007). A framework for assessing health systems from the public’s perspective: the ALPS approach. *International Journal of Health Services*, 37(2): 363-378.

(This article clarifies the ‘Affordability Ladder’ framework for considering equity issues in health service use from a household perspective and in relation to different types of illness)

TIMING OF THE CASE STUDY

Before handing out the case study, you should briefly introduce the concept of access, highlighting the three main dimensions of access (availability, affordability and acceptability). You should also clarify the difference between direct and indirect costs. No further introduction is required – the discussion of the case study in plenary format can be used to highlight the importance of the household perspective and draw out key aspects of the ALPS framework for considering household related issues.

The case study will require 2.5 – 3 hours to complete:

- One and a half hours should be set aside to allow participants to read the case study material and discuss the questions in groups.
- A further hour should be allowed for briefly reviewing the case study questions and drawing out key issues (such as the importance of the household perspective).
- If appropriate, a brief presentation on the ALPS conceptual framework could be provided thereafter to summarise the household perspective on illness and health care use.

KEY ISSUES FOR DISCUSSION

1. What types of treatment do people use?

It is helpful to highlight the interchangeable use of the public and private sector services and the use of different types of facilities (primary care versus hospital). There is some use of self-treatment and herbal remedies, particularly in the early stages of an illness.

2. Why do people use these types of treatment?

Often, people were referred to a particular hospital for treatment or they chose to use a facility closer to them because of travel and indirect (loss of productive time) costs.

3. Do the types of services used differ by the socio-economic status of the household?

All households went to government hospitals once the seriousness of the illness was realised. In low income households, there is sometimes initial self-treatment before care is sought at a hospital. Higher income households may switch to using private providers which are located nearby (rather than more distant higher level public hospitals), but when the costs of private care become a burden, they often revert to public sector care.

4. What are the main barriers to care in terms of

- a. Availability of care: geographic distance to the facility which is able to treat illness was considerable in all cases, even for Sena who lives in Colombo; very few facilities offer diabetes and cancer care although some of the provincial hospitals are now developing capacity for treating cancer; prescribed drugs are not always available at public facility
- b. Affordability of care: not having to pay a fee for care is important, but transport costs are high; there are 'informal fees' such as having to buy a 'number' for the queue; there are other direct costs such as special foods; and indirect costs are considerable
- c. Acceptability of care: not mentioned often, but in one case – Sena – there was dissatisfaction with the lack of time devoted by doctor

5. What direct costs of seeking health care do patients face?

Transport (for the patient and sometimes an accompanying person), accommodation if the facility is very far away, special foods, etc.

6. What indirect costs of seeking health care do patients face?

Loss of productive time travelling to and waiting at the facility, and also due to the illness itself (if the disease is not properly managed), particularly in terms of being unable to undertake the activities normally undertaken. There are also 'other costs' that can't be quantified, such as social isolation)

7. Calculate:
- The proportion of the household income that Seela's households spent on the direct costs of inpatient care for the total 5 months (total income of Rs6,000 per month for 5 months = Rs30,000; total costs of Rs40,100 = 134% of the household income during this period)
 - The proportion of the household income that Seela's household spent on the direct costs of outpatient care each month (Rs1,500 per month = 25% of monthly income)
 - The proportion of income that the Seela's households lost each month through the indirect costs of her illness. (Rs900 per month = 15% of monthly income)
8. List the coping strategies for health care costs that were most commonly used by households and the impact of illness costs on household livelihoods.
- Many households incur debts (borrow or get supplies on credit at the shop), sell assets (e.g. pawn jewellery, sell land), remove children from school so that they can take on the work of the sick person and/or attempt to generate wage income. Where productive assets are sold (e.g. land) this can have a substantial adverse impact on livelihoods, income generation may reduce for the chronically ill, the impact of children not receiving an education can have long-term adverse livelihood implications, etc.
9. Consider the potential policy options to reduce household's barriers to health care in Sri Lanka.
- A range of issues could be raised here. The key issue seems to be related to availability, which in turn impacts dramatically on affordability. Given the growth in non-communicable diseases in Sri Lanka, staff in district hospitals may need to be trained in diagnosing and treating these diseases, and the necessary equipment and medicines made available at this level. There could be 'monthly clinics' at district hospitals for particularly prevalent non-communicable disease (e.g. diabetes) with a specialist visiting from one of the tertiary facilities, for diagnosis, treatment initiation and monitoring of patients. Subsidised patient transport could also be considered. The feasibility of subsidised 'special food' (e.g. for diabetics) could also be explored.

After briefly reviewing these questions in plenary, key issues from the household perspective should be raised:

- Often no care is sought, or treatment is stopped
- There may also be inappropriate self-treatment
- Sri Lanka has a very good distribution of public sector facilities, with relatively good quality of care, but this is rare in low- and middle-income countries where it is very difficult to access good professional care
- There are often differences in care sought according to the socio-economic status of the household (and sometimes in terms of gender and other factors)
- The burden of direct and indirect costs can be severe, even in a country like Sri Lanka where there is no official fee for any public sector health services (transport costs often very high and lost productive time is a major issue)
- These costs can impoverish households, particularly where large debts are incurred and productive assets sold